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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

EDEN SURGICAL CENTER, a California medical corporation,

Plaintiff,

vs.

TENET HEALTHCARE CORPORATION, C/O TENET BENEFITS ADMINISTRATION COMMITTEE, in its capacity as plan administrator; TENET BENEFITS ADMINISTRATION COMMITTEE,

Defendants.

Case No. CV09 07156 FMO

MEMORANDUM OF POINTS AND AUTHORITIES BY TENET BENEFITS ADMINISTRATION COMMITTEE IN OPPOSITION TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

Date: June 2, 2010
Time: 10:00 a.m.
Place: Courtroom F

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION.

Plaintiff Eden Surgical Center's Motion consists of a mass of confusing factual assertions that appear to suggest that Tenet Benefits Administration Committee bears responsibility for the denial of the Patient's claim for benefits submitted by Eden and thus, statutory penalties should be awarded to Eden. However, Tenet was not responsible for the denial of the Patient's claim for benefits. Plaintiff's claim was denied due to Eden's failure to submit the requisite information in a timely manner.

Moreover, the denial of Eden's claim is not at issue here. The issue is whether Eden was assigned the right by the Patient to request from Tenet disclosure of documents, and assuming that right was assigned, whether or not Tenet provided the documents required under 29 U.S.C. § 1024(b)(4).

As a preliminary matter, Plaintiff lacks standing as neither the Tenet Employee Benefit Plan, the PacifiCare-Tenet Contract (PPO Policy), Summary Plan Description, or assignment form executed by the Patient allow for the assignment of document disclosure rights from the Patient to Eden Surgical Center. Moreover, even if Plaintiff had standing because such an assignment was permissible under the documents, Tenet has disclosed all documents it was required to disclose under the statute. Lastly, to the extent Eden claims that it lacked information explaining a denial of benefit determination by PacifiCare and thus, needed additional information from Tenet, such an assertion is unbelievable. The Explanation of Benefits issued by PacifiCare clearly stated that Eden failed to initially provide the requisite codes, and failed to appeal such denial in a timely manner.

This is nothing more than Eden's attempt to utilize a document disclosure claim against Tenet as leverage to obtain payment on its improperly submitted claim from PacifiCare. Such transparent motives should not be rewarded, and Plaintiff's motion for summary judgment should be denied it its entirety.

II. FACTUAL BACKGROUND.

Tenet Benefits Administration Committee is the administrator of the Tenet Employee Benefit Plan. Iba Decl., Exh. "A" at p. 57.[1] PacifiCare is the insurance carrier and claims administrator of the Plan. Id., at ¶ 3.

No documents exist which evidence an assignment of document disclosure rights from the Patient to Eden Surgical Center. Section 18.4 of the Tenet Employee Benefit Plan contains a prohibition against assignments: "[N]o interest in or benefit payable under the Plan will be subject in any manner to . . . assignment . . . ." Iba Decl., Exh. "A" at p. 76. The PacifiCare-Tenet Contract (PPO Policy) and Summary Plan Description also contains a prohibition against assignments, except for "covered expenses" which would not include any document disclosure rights. Id., Exh. "B" at p. 216; Exh. "C" at p. 306. Lastly, the assignment executed by the Patient to Eden Surgical Center only applies to the following three situations: (1) an administrative claims process; (2) any appeal or review process for a denied claim; or (3) any legal process, necessary to collect claims submitted for health insurance benefits. Id., Exh. "K." None of these situations are applicable to this situation – a claim regarding document disclosure rights.

Contrary to Plaintiff's factual assertions, Tenet did not issue a denial of a benefit of the Patient's claim. Such denial was issued by PacifiCare. And, the reasons for the benefit denials by PacifiCare, not Tenet, are readily apparent. In November 2006, PacifiCare issued an Explanation of Benefits denying payment on Eden's claim, alleging that the "[c]laim was closed due to lack of response to prior request for additional information. Services will be considered and patientation responsibility calculated when information is received." See EDEN MSJ 003-004, attached to Eden Surgical Center's Compendium of Exhibits filed concurrently with Eden's Motion for Summary Judgment on April 21, 2010. In December 2006,

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[1] See Iba Declaration submitted concurrently with Tenet's Motion for Summary Judgment on April 21, 2010.

PacifiCare informed Eden that "we have determined that although we are in receipt of the medical records submitted by your office, we are still in need of a corrected billing with the CPT codes of the services performed." EDEN MSJ 012. In August 2009, PacifiCare issued an adverse benefit determination that the Patient's claim was ineligible because "claims must be submitted within the timely filing limit in order to be paid." EDEN MSJ 042. Eden was not denied any opportunity to know the status or reasons for the adverse benefit determinations.

This litigation is nothing more than another attempt by Eden Surgical Center to obtain reimbursement on PacifiCare's denial of the Patient's claim. Indeed, when Dr. Laurence Reich first corresponded with Tenet in 2009, he indicated that he was seeking its assistance to resolve the alleged failure of PacifiCare to process the Patient's claim properly. Id., ¶ 5, Exh. "D" at p. 354. His motives were always readily apparent.

On July 22, 2009, Dr. Reich told Ms. Iba, "If PacifiCare resolves this claim appropriately and expeditiously, I will recommend to Eden's governing board that the matter between it and Tenet conclude." Id., Exh. "H" at p. 376. On August 4, 2009, Dr. Reich threatened, "[E]ither this claim is paid immediately and properly without re-pricing or discounting or I will recommend to Eden's Governing Board that the organization commence a 1132(a)(1)(A) action against Tenant." Id., Exh. "I" at p. 379. Most telling is Dr. Reich's August 5, 2009 correspondence where he indicated that "it appears the controversy is concluding 'due to a' flurry of communications with a supervisor at PacifiCare." Id., Exh. "J" at 382.

Despite its belief that Eden lacked standing to request any Plan documents, in order to avoid a dispute, Tenet produced the Tenet Employee Benefit Plan, the PacifiCare – Tenet Contract (PPO Policy) and the Summary Plan Description. Id., ¶ 6, Exhs. "G" at p. 374, "I" at p. 378, and "J" at p. 381. Tenet also voluntarily forwarded all medical records provided by Plaintiff regarding the Patient to PacifiCare and requested that it reprocess the claim. Iba Decl., ¶ 9.

Moreover, Iba repeatedly asked Dr. Reich if there were additional documents he needed. Id., Exhs. "G" at p. 374, "I" at p. 378, and "J" at p. 381. Most telling is that following each of Ms. Iba's offers on July 15, 2009, August 4, 2009, and August 5, 2009 to provide additional documents, Dr. Reich never requested additional documents and, instead, made clear that if the Patient's claim was paid by PacifiCare, the matter between Eden and Tenet would conclude. Id., Exhs. "H" at p. 376, "I" at p. 379, and "J" at p. 382.

Despite Tenet's disclosure of documents and repeated requests that Reich clarify the information he needed, this litigation commenced. This is not surprising considering Dr. Reich and/or Eden Surgical Center have been plaintiffs in at least forty cases filed under the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") since 1995, with fifteen filed in 2009 alone.[2] Quinn Decl.,

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[2] See, e.g., (1) Eden Surgical Center v. Boyd Coffee Company, 10cv-0884 (C.D. Cal.); (2) Eden Surgical Center v. B Braun Medical, Inc., 09cv-1011 (C.D. Cal.); (3) Eden Surgical Center v. Budco Group, Inc., 09cv-3991 (C.D. Cal.); (4) Eden Surgical Center v. California Motor Car Dealers Association, 09cv-6456 (C.D. Cal.); (5) Eden Surgical Center v. Centric Group LLC, Health Benefits Plan, 09cv-7154 (C.D. Cal.); (6) Eden Surgical Center v. Dollar Thrifty Automotive Group, Inc., 09cv-6454 (C.D. Cal.); (7) Eden Surgical Center v. Emerson Electric Co Self-Funded Medical PLA, 09cv-2554 (C.D. Cal.); (8) Eden Surgical Center v. Experian Information Solutions, Inc., 09cv-489 (C.D. Cal.); (9) Eden Surgical Center v. General Electric Company, 09cv-4301 (C.D. Cal.); (10) Eden Surgical Center v. Marvin Engineering Company, Inc., 09cv-1407 (C.D. Cal.); (11) Eden Surgical Center v. New Breed, Inc. Health Plan Administrator, 09cv-4031 (C.D. Cal.); (12) Eden Surgical Center v. Ozburn-Hessey Logistics, 09cv-2965 (C.D. Cal.); (13) Eden Surgical Center v. Rudolph Foods Company, Inc., 09cv-3060 (C.D. Cal.); (14) Eden Surgical Center v. Sprint Nextel Medical Plan Administrator, 10cv-01424 (C.D. Cal.); (15) Eden Surgical Center v. St. Jude Medical, Inc., 09cv-1253 (C.D. Cal.); (16) Eden Surgical Center v. The Administrative Committee of the Time Warner Cable Benefits Plan, 10cv-0920 (C.D. Cal.); (17) Eden Surgical Center v. WW Grainger, Inc., 09cv-302 (C.D. Cal.); (18) Reich v. Aetna US Healthcare, et al., 98cv-5212 (C.D. Cal.); (19) Reich v. Boeing Company, 99cv-11805 (C.D. Cal.); (20) Reich v. Boilermakers Nat'l, 96cv-7215 (C.D. Cal.); (21) Reich v. Charter Communications Inc., 04cv-9126 (C.D. Cal.); (22) Reich v. CIFWP, 98cv-7219 (C.D. Cal.); (23) Reich v. Countrywide Cred. Ind., 03cv-7004 (C.D. Cal.); (24) Reich v. CIGNA Healthcare, Inc., 01cv-04076 (C.D. Cal.); (25) Reich v. Deutsche Bank, 99cv-11804 (C.D. Cal.); (26) Reich v. DHL Premium Plan, 04cv-8322 (C.D. Cal.); (27) Reich, et al. v. Sara Gault, 95cv-3657 (C.D. Cal.); (28) Reich v. Group Medical Expense Benefits Plan for Broadcam Corporation et al., 04cv-169 (C.D. Cal.); (29) Reich v. Health Net of CA Inc., 03cv-1405 (C.D. Cal.); (30) Reich v. Informal Rockwell, et al., 01cv-4884 (C.D. Cal.);

Exh. "A" submitted concurrently herewith Tenet's Motion for Summary Judgment on April 21, 2010. Their status as repeat ERISA litigants supports the proposition that the requested documents were sought to fuel litigation, rather than to analyze the denial of benefits. This is further evidenced by the fact that Eden has never sought the documents during the pendency of this litigation. Eden has not served a single request for production of documents, nor during this action has it sought to subpoena PacifiCare for production of documents. Quinn Decl., ¶ 3.

III. ARGUMENT AND AUTHORITIES.

A. Plaintiff Cannot Seek Damages From Tenet for PacifiCare's Alleged Improper or Untimely Processing of the Patient's Benefit Claim.

The Plaintiff appears to claim that the sole purpose of ERISA is to provide protection for, and remedies to, employees participating in employee health and benefit programs. However, ERISA also limits the remedies available to plan participants and beneficiaries, and provides that the plan document controls the nature and extent of the benefits available. Massachusetts Mut. Life Ins. Co. vs. Russell, 473 U.S. 134 (1985); 29 U.S.C. § 1104(a)(1)(D). In holding that ERISA does not include a cause of action for extracontractual damages caused by improper or untimely processing of benefit claims, the Supreme Court stated:

"The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted, however, provide strong evidence that Congress did

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(31) Reich v. Lakeshore Learning, 98cv-7711 (C.D. Cal.); (32) Reich v. Merchant & Gould PC, 00cv-515 (C.D. Cal.); (33) Reich v. Novartis Pharm. Corp., 04cv-10414 (C.D. Cal.); (34) Reich v. Teletech Holdings, et al. , 01cv-4261 (C.D. Cal.); (35) Reich v. Time Warner Inc., 00cv-4213 (C.D. Cal.); (36) Reich v. Tricon Global, 00cv-9125 (C.D. Cal.); (37) Reich v. Tricon Global, 01cv-62 (C.D. Cal.); (38) Reich v. United Airlines Med, et al., 97cv-9266 (C.D. Cal.); (39) Reich v. Universal Studios, et al., 99cv-1254 (C.D. Cal.); (40) Reich v. UPS Health and Welfare Package, 04cv-833 (C.D. Cal.); (41) Reich v. Walt Disney Company, et al., 00cv-8792 (C.D. Cal.); and (42) Reich v. United Airlines P&W, 95cv-6222 (C.D. Cal.).

not intend to authorize other remedies that it simply forgot to incorporate expressly. The assumption of inadvertent omission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a 'comprehensive and reticulated statute.' . . . The presumption that a remedy was deliberately omitted from a statute is strongest when Congress has enacted a comprehensive legislative scheme including an integrated system of procedures for enforcement." Russell, 473 U.S. at 146, 147. Since ERISA includes a comprehensive enforcement system, only causes of action explicitly set forth in the statute are permitted.

B. The Plaintiff Has No Standing to Sue.

The Plaintiff's Complaint contains only a single cause of action – a claim for penalties for alleged document disclosure violations under 29 U.S.C. § 1132(a)(1)(A). Since that code section permits suits only by a participant or beneficiary, and the Plaintiff concedes that it is neither a participant nor a beneficiary, Plaintiff's attempt to rely on an assignment from a plan participant as a basis for standing to sue fails. Complaint, ¶ 6.

1. No assignment of document disclosure rights was executed by the Patient to Plaintiff.

The Ninth Circuit has never extended standing to sue for document disclosure violations to an assignee of a plan participant. Furthermore, the Ninth Circuit has specifically held that non-assignment clauses included in plan documents are legal and binding in this jurisdiction. Davidowitz v. Delta Dental Plan of California, Inc., 946 F.2d 1476 (9th Cir. 1991). The Plaintiff has failed to analyze or even cite this Ninth Circuit decision. Instead, the Plaintiff attempts to rely on the Misic case, which did not involve a claim for document disclosure violations, and did not involve a plan document which contained a non-assignment provision. See Misic v. Building Service Employees Health and Welfare Trust, 789 F.2d 1374 (9th Cir. 1986). The Davidowitz decision clearly distinguishes the Misic case, and renders

the Misic case inapposite to situations such as this where the plan document contains an anti-assignment clause. Davidowitz, 946 F.2d at 1480, 1481. The Davidowitz case was followed in a later Ninth Circuit decision. Long Beach Mem. Med. Center v. California Mart Employee Benefit Plan, 1999 U.S. App. LEXIS 3346 (9th Cir. 1999).

The United States Supreme Court has held that "ERISA carefully enumerates the parties entitled to seek relief under [29 U.S.C. § 1132]; it does not provide anyone other than participants, beneficiaries, or fiduciaries with an express cause of action . . . ." Franchise Tax Board of the State of California v. Construction Laborers Vacation Trust for Southern California, 463 U.S. 1, 27 (1983). The Ninth Circuit has also held that "[i]n the absence of some indication of legislative intent to grant additional parties standing to sue, the list in [29 U.S.C. § 1132] should be viewed as exclusive." Simon v. Value Behavioral Health, Inc., 208 F.3d 1073, 1082 (9th Cir. 2000), quoting Chemung Canal Trust Co. v. Sovran Bank/Maryland, 939 F.2d 12, 14 (2nd Cir. 1991). "[U]nder traditional principles of statutory interpretation, Congress' explicit listing of who may sue . . . should be understood as an exclusion of others . . . ." Silvers v. Sony Pictures Entertainment, Inc., 402 F.3d 881, 885 (9th Cir. 2005). When a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions. Id.

Section 18.4 of the Tenet Employee Benefit Plan, which is entitled Non-Alienation of Benefits states, in relevant part:

"[N]o interest in or benefit payable under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt by a Covered Person to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge the same will be void and of no effect; nor will any interest in or benefit payable under the Plan be in any way subject to any legal or equitable process, including garnishment, attachment, levy, seizure, or lien."

In the Ninth Circuit, it is clear that this broad anti-assignment provision is enforceable. Davidowitz v. Delta Dental Plan of California, Inc., 946 F.2d 1476 (9th Cir. 1991).

Since the Ninth Circuit prohibits assignments in cases where the plan document contains a non-assignment provision, and since the Ninth Circuit has never allowed assignment of standing in a case involving an allegation of document disclosure violations, the Plaintiff does not have standing to sue in this case.

Moreover, the assignment of rights in this case did not apply to document disclosure rights. The assignment executed by the Patient to Eden Surgical Center only applies to the following three situations: (1) an administrative claims process; (2) any appeal or review process for a denied claim; or (3) any legal process, necessary to collect claims submitted for health insurance benefits. Id., Exh. "K."

Plaintiff claims that the assignment executed by the Patient assigned the right to pursue document disclosure. Plaintiff is mistaken. Plaintiff selectively quotes the language from the assignment in an effort to bolster its case. The "right to assert ALL causes of action for judicial review" applies "if my claim for benefits is administratively denied in whole or in part . . . ." Since Plaintiff is not seeking judicial review of a denied claim, the assignment does not apply to this case brought under § 1132(a)(1)(A) for statutory penalties for alleged disclosure violations. Furthermore, the assignment of relief as a "claimant" under § 1132(c) is ineffective since 29 U.S.C. § 1132(c) does not use the word "claimant." The regulations under 29 U.S.C. § 1133 use the word "claimant" in the context of benefit claims and appeals. As such, the assignment form relates only to benefits claims, which is consistent with the remainder of the form and the cases described below.

As this court has recently ruled in two virtually identical cases brought by the same Plaintiff, the assignment form executed by the plan beneficiary did not assign to the Plaintiff the right to request plan documents, and, therefore, the Plaintiff has no standing to sue. See Eden Surgical Center v. Rudolph Foods Company, Inc., CV

09-3060 SVW (MANx) (C.D. Cal. Sept. 10, 2009); Eden Surgical Center v. B. Braun Medical, Inc., CV 09-1011 SVW (AJWx) (C.D. Cal. Sept. 10, 2009). The second sentence of the purported assignment form at issue in this case, as well as in the Rudolph and Braun Medical cases, is identical. See Request for Judicial Notice submitted concurrently with Tenet's Motion for Summary Judgment on April 21, 2010, Exh. "A" at p. 8 (Rudolph Order); Exh. "B" at p. 29 (Braun Medical Order).

As indicated in the Rudolph Order (RJN, Exh. "A" at pp. 21-23) and in the Braun Medical Order (RJN, Exh. "B" at pp. 41-42):

> The unambiguous language of the 'Assignment of Benefits and Rights; Appointment of Administrative Representative,' uncontradicted by any extrinsic evidence in the record, establishes that the Plan participants never assigned to Eden the right to bring the present action. Their assignment is only effective during the administrative and legal processes enumerated in the second sentence of their 'Assignment of Benefits and Rights; Appointment of Administrative Representative.' . . . This list does not include a suit for document disclosure violations. To the extent that the Plan participants assigned to Eden the right to bring claims under § 1132(c), that assignment is only effective during suits 'necessary to collect claims . . . for health insurance benefits.'

As in Rudolph and Braun Medical, supra, the instant case involves a claim for statutory penalties arising from an alleged failure to disclose the requisite documents. The Assignment of Benefits and Rights; Appointment of Administrative Representative at issue in this case does permit the assignment of this claim. As such, Plaintiff has no standing in this case.

2. The Plan Document and Certificate are not contradictory; both prohibit assignment of document disclosure rights.

In an attempt to circumvent the Ninth Circuit decision in the Davidowitz case, the Plaintiff attempts to find contradictions in the clear plain language. In claiming

that the alleged contradiction must be resolved in the Plaintiff's favor, the Plaintiff relies on Alexander Mfg., Inc. Employee Stock Ownership Plan and Trust v. Illinois Union Insurance Co., 560 F.3d 984 (9th Cir. 2009). However, the Alexander case involves Oregon insurance law, and is not relevant to this ERISA case.

The Plaintiff also attempts to rely on a clearly distinguishable case, in which a plan document stated that an individual was eligible for a retirement plan, while the summary plan description indicated that the individual was not eligible. Bergt v. Retirement Plan for Pilots Employed by MarkAir, Inc., 293 F.3d 1139 (9th Cir. 2002). There is no such contradiction in this case.

The Bergt case cites favorably to Pisciotta v. Teledyne Industries, Inc., 91 F.3d 1326 (9th Cir. 1996). As indicated in the Pisciotta case, an insurance certificate is not an official summary plan description, and the plan document language takes precedence over the insurance certificate. Pisciotta, 91 F.3d at 1330. Therefore, the insurance certificate cited by the Plaintiff is not controlling because the certificate is not an official plan document. The clear anti-assignment language of the Tenet Employee Benefit Plan is controlling in this case. It has long been the rule in this jurisdiction that an unambiguous provision in the governing plan document governs over any allegedly contrary information in other documents or statements. Watkins v. Westinghouse Hanford Co., 12 F.3d 1517 (9th Cir. 1993); Moran v. Aetna Life Ins. Co., 872 F.2d 296, 299-300 (9th Cir. 1989).

In the Pisciotta case, the court also held that, even if the insurance certificate was a summary plan description, the certificate was not controlling because it contained the following disclaimer: "This booklet describes provisions of the group insurance program contained in the contract between the company and the insurance carrier. The contract shall be the controlling document." Id. at p. 1331. The Pisciotta court concluded as follows: "The disclaimer clearly stated that the contract was the controlling document. The contract was available for review by any employee who wished to see it. Therefore, the reservation was effective." Id. As

such, the plan document which permitted health plan amendments and cost increases controlled over the summary document which promised free lifetime medical coverage. Id.

The insurance certificate at issue in this case similarly provides, in large, bold type, that it is only a description of the health plan benefits, that additional terms are contained in the governing document, and that a copy of the governing document will be furnished upon request and is available at the employer's personnel office. Iba Decl., Exh. "C" at p. 34. Therefore, plan participants clearly are on notice that the plan document is controlling and is available upon request. As such, the anti-assignment provision of the plan document is enforceable.

In any event, there is no contradiction between the plan document and the insurance certificate in this case. The language of the insurance certificate allows assignments of payments for covered benefits to health care providers, but does not provide for assignments of disputed benefits or rights relating to alleged document disclosure violations. It is perfectly consistent to allow assignment of the payment of benefits that are agreed to be covered under the plan, while refusing to allow assignments of disputed benefits or other rights. See LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores, Inc., 298 F.3d 348 (5th Cir. 2002). While the assignment in LeTourneau effectively assigned the right to receive payments for duly covered claims, it was ineffective to assign other contractual or statutory rights under ERISA. Id. at 352. Therefore, the health care provider had no standing. Id. at 353. Similarly, under the plan language at issue in this case, the Plaintiff has no standing to sue for alleged document disclosure violations.

3. There is no standing in a penalty suit where, as here, no action for benefits is brought.

The Plaintiff also lacks standing because an action for document disclosure violations under 29 U.S.C. § 1132(a)(1)(A) cannot be brought independently of a claim for plan benefits under 29 U.S.C. § 1132(a)(1)(B). Johnson v. Buckley, 356

F.2d 1067, 1077 (9th Cir. 2004); Crotty v. Cook, 121 F.3d 541, 544 n.4 (9th Cir. 1997) ("To have standing, Crotty must be seeking benefits under the plans."). Since the Plaintiff is not seeking to recover plan benefits, the Plaintiff lacks standing to assert a violation of ERISA's disclosure requirements. Johnson, 356 F.3d at 1077.

The Plaintiff misconstrues the Moran decision when it asserts that decision permits a claim for disclosure violations that was brought without a concomitant claim for benefits. Moran v. Aetna Life Ins. Co., 872 F.2d 296 (9th Cir. 1989). That case grants summary judgment against a plaintiff seeking statutory penalties because the plaintiff brought suit against a party other than the plan administrator. Id. The Moran decision does not permit a suit for statutory penalties for alleged disclosure violations in a case where the plaintiff fails to include a claim for benefits. Id.

Summary judgment should be granted in favor of Tenet because a claim for penalties under 29 U.S.C. § 1132(a)(1)(A) cannot be brought independently of a claim for benefits under 29 U.S.C. § 1132(a)(1)(B).

4. Tenet has not waived its anti-assignment defense.

The Plaintiff claims, without citing any authority, that Tenet has waived its anti-assignment defense because Tenet did not inform Eden prior to litigation that it was barred from pursuing payment by an anti-assignment provision. While the Plaintiff made an administrative claim for benefit payments prior to litigation, it did not make an administrative claim for penalties for alleged disclosure violations. Once again, Plaintiff erroneously suggests that Tenet was responsible for the denial of payment of Plaintiff's benefit claim in an effort to muddy the issues. There was no prior opportunity to raise an anti-assignment defense to a claim for statutory penalties for alleged disclosure violations, and, therefore, there has been no waiver of such a defense.

C. Tenet Fully Complied With Its ERISA Disclosure Obligations.

1. ERISA's disclosure requirements have been satisfied.

Even if the Plaintiff has standing, which we dispute, the Defendant has already furnished to the Plaintiff all documents that must be furnished under ERISA. The ERISA document disclosure requirement is found in 29 U.S.C. § 1024(b)(4):

> "The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. The administrator may make a reasonable charge to cover the cost of furnishing such complete copies. The Secretary [of Labor] may by regulation prescribe the maximum amount which will constitute a reasonable charge under the preceding sentence."

2. Only formal documents must be furnished.

It is undisputed that the Defendant has furnished to the Plaintiff all requested documents that come within the requirements of the statute. The Plaintiff requested the summary plan description, plan document, administrative contract and any contract between Tenet, PacifiCare, United Health and Ingenix/Viant and any other relevant claims subsidiary, as well as any re-pricing or charge index data base utilized in creating an adverse benefit determination of the instant claim. Iba Decl., Exh. "D" at p. 357. Tenet produced the Tenet Employee Benefit Plan, the PacifiCare - Tenet Contract (PPO Policy) & Summary Plan Description. Iba Decl., ¶ 6, Exhs. "G" at p. 374, "I" at p. 378, and "J" at p. 381.

To the extent Plaintiff claims that other unofficial documents should have been produced, Plaintiff is mistaken. Ancillary documents, such as unofficial documents used to determine benefit levels in a particular case, are not required to be furnished under 29 U.S.C. § 1024(b) or § 1132(c)(1)(B). Shaver v. Operating

Engineers Local 428 Pension Trust Fund, 332 F.3d 1198 (9th Cir. 2003); Board of Trustees of the CWA/ITU Negotiated Pension Plan v. Weinstein, 107 F.3d 139 (2nd Cir. 1997). Both cases analyzed the term "other instruments" and held that it refers to formal documents that govern the plan and not all documents that may reference how the plan conducts operations.

"Barring indicia to the contrary, the broad term 'other instruments,' should be limited to the class of objects that specifically precedes it. Shaver, 332 F.3d at 1202. The statute mentions only official legal documents, and the reference to "other instruments" does not expand the type of documents to be furnished under 29 U.S.C. § 1024(b). Id.

Similarly, the Weinstein court stated that the "other instruments" clause was meant to refer to formal documents that govern the plan, not to all documents by means of which the plan conducts operations. Weinstein, 107 F.3d at 143. 29 U.S.C. § 1024(b) requires the disclosure of only the documents described with particularity in the statute and "other instruments" similar in nature. Id. Although a document other than an official governing document may contain information about a plan, the administrators are not bound by the document. Weinstein, 107 F.3d at 144. While such a document may describe various rights and obligations, it does not establish those rights and obligations, and therefore is not a formal instrument governing a plan's operations. Id. at 144, 145.

3. Informal advisory opinions do not expand the list of documents that must be furnished.

The Plaintiff attempts to avoid the limits on document disclosure in the Ninth Circuit, as set forth in the Shaver case, supra, by citing to an unofficial and non-binding advisory opinion letter issued by the Department of Labor, and by misconstruing the Chevron case, infra, to attempt to give effect to such advisory opinion letter.

The Chevron case analyzed official regulations of the Environmental Protection Agency, which were published in the Federal Register. Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837 (1984). However, the Advisory Opinion Letter cited by the Plaintiff is an unofficial document that binds only the parties who requested the opinion, and is not entitled to deference by this court.

A Department of Labor Advisory Opinion is not binding authority. Patelco Credit Union v. Sahni, 262 F.3d 897, 908 (9th Cir. 2001). "Only the parties described in the request for opinion may rely on the opinion ..." Id. (quoting ERISA Procedure 76-1); see also Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 318, 326 n.5 (1992) (refusing to give a Department of Labor Advisory Opinion any deference under the Chevron decision); Barker v. Pick N Pull Auto Dismantlers, Inc., 819 F.Supp. 889, 896 n.11 (E.D. Cal. 1993) (stating that a Department of Labor Advisory Opinion is binding only on the parties to the letter and is not entitled to deference).

For the foregoing reasons, the Defendant has furnished to the Plaintiff all requested documents that come within the statute, and the Plaintiff is not entitled to recover penalties for failure to disclose documents.

4. Statutory penalties do not apply to documents required by regulations.

The Plaintiff argues that the Sgro case indicates that documents required to be furnished under regulations can give rise to statutory penalties. See Sgro v. Danone Waters, 532 F.3d 940 (9th Cir. 2008).

Even if the Plaintiff has standing, which we dispute, the penalty provision of 29 U.S.C. § 1132(c)(1)(B) applies only to documents required by statute, not to documents called for under the Code of Federal Regulations. Plaintiff's allegation that the plan administrator failed to furnish documents described in 29 C.F.R. § 2560.503-1 does not result in statutory penalties under 29 U.S.C. § 1132(c).

Penalty provisions should be construed strictly, and one is not to be subjected to a penalty unless the words of the statute plainly impose it. Commissioner v. Acker, 361 U.S. 87 (1959). 29 U.S.C. § 1132(c)(1)(B) applies only to a request for information which is "required by this subchapter [Subchapter I of Chapter 18 of Title 29 of the United States Code]." Since no reference is made in 29 U.S.C. § 1132(c)(1)(B) to requests for information described in regulations, the penalty provision should not apply to documents required only under regulations.

The Ninth Circuit recently affirmed a district court ruling, which held that "the statutory penalty authorized by 29 U.S.C. § 1132(c)(1) only applies where an administrator fails to provide information it is required to furnish by statute. See 29 U.S.C. §§ 1132(c)(1) (stating, 'required by this subchapter to furnish'). The penalty does not apply where a duty to furnish documents is imposed only by regulation." Younkin v. Prudential Ins. Co., 2007 U.S. Dist. LEXIS 5376 (D. Mont. 2007), aff'd in part and rev'd in part on other grounds in Younkin v. Prudential Ins. Co., 288 Fed. Appx. 344 (9th Cir. 2008). A similar holding was reached in Fergus v. Standard Ins. Co., 27 F.Supp.2d 1247, 1252-1253 (D. Or. 1998).

Courts outside the Ninth Circuit have held that the penalty does not apply to information requests under the regulations. The Third Circuit has held that plan administrators incur no personal liability under 29 U.S.C. § 1132(c)(1)(B) for failure to fulfill obligations imposed by 29 C.F.R. § 2560.503-1. Groves v. Modified Retirement Plan for Hourly Paid Employees of the Johns Mansville Corp., 803 F.2d 109, 116 (3rd Cir. 1986). Congress shall not be deemed to have authorized an administrative agency to decide what conduct should be penalized, unless Congress has expressly granted that power. Id. at 117 (citing United States v. Eaton, 144 U.S. 677 (1892)). Congress has not done so, and penalties should not be assessed for violations of 29 C.F.R. § 2560.503-1. Groves, 803 F.2d at 118. The Sixth Circuit has reached the same conclusion. Stuhlreyer v. Armco, Inc., 12 F.3d 75, 79 (6th Cir. 1993). The Seventh Circuit also agrees with this holding. Wilczynski v.

Lumbermens Mutual Casualty Co., 93 F.3d 397, 406-407 (7th Cir. 1996). At least one district court from outside the Ninth Circuit also concurs. Brucks v. Coca-Cola Co., 391 F.Supp.2d 1193, 1212 n.17 (N.D. Ga. 2005) (stating that if Congress intended for section 1132(c) to apply to the Department of Labor's regulations, it would have so indicated, instead of authorizing penalties only for violations of the subchapter, by which it was referring to the ERISA statute).

Any reliance upon Sgro v. Danone Waters, 532 F.3d 940 (9th Cir. 2008), for the proposition that "ERISA's remedies provision gives . . . a cause of action to sue a plan 'administrator' who doesn't comply with a 'request for . . . information'" is misplaced. In Sgro, the court excluded the key words "which such administrator is required by this subchapter to furnish" in its quoted language from 29 U.S.C. § 1132(c)(1). Since the court dismissed the claim for failure to specify which defendant the documents were requested from, the court did not analyze the language of 29 U.S.C. § 1132(c)(1)(B) which limits the penalty to information "required by this subchapter," and its single sentence on the subject should be considered dicta.

Furthermore, 29 C.F.R. § 2560.503-1 contains a specific remedy for failure to furnish documents required thereunder, and it does not include a monetary penalty. If such a failure occurs, the claimant is deemed to have exhausted the administrative remedies available under the plan and shall be entitled to sue for benefits and receive a *de novo* judicial review. Booton v. Lockheed Med. Benefit Plan, 110 F.3d 1461, 1465 (9th Cir. 1997); 29 C.F.R. § 2560.503-1(l); 65 F.R. 70246, 70256 (Nov. 21, 2000).

For these reasons, an alleged failure to furnish documents described in 29 C.F.R. § 2560.503-1 does not result in statutory penalties under 29 U.S.C. § 1132(c).

5. All documents required by regulation have been furnished.

Even if documents required by regulations could give rise to a penalty, no penalty would apply in this case because all relevant documents described in 29 C.F.R. § 2560.503-1 were furnished to the Plaintiff. Since the Plaintiff's claim was denied for being filed after the deadline described in the Insurance Certificate, it is unclear what documents the Plaintiff is demanding because the Insurance Certificate has already been furnished to the Plaintiff.

6. Plaintiff received explanations of benefits setting forth the reasons for denial of the claim.

Plaintiff also complains that the explanation of benefits it received on August 25, 2009 is somehow inadequate. The explanation of benefits clearly explains that the claim was not submitted within the timely filing limit under the provider contract, certificate, and/or state law. The certificate states the following in the "Appealing a Company Decision" section on page 49:

> "The appeal must be filed within 180 days of receiving a denial notice or explanation of benefits."

Since the claim was initially denied in an explanation of benefits received by the Plaintiff in 2006, an appeal filed in 2009 clearly is not timely filed within the 180-day period required by the certificate. There is nothing mysterious or misleading about the fact that the Plaintiff delayed in appealing a denied benefit for over two years, and had the appeal denied on the basis that it did not meet the 180-day deadline.

The Plaintiff misstated the law when it claimed that the reference to state law in the explanation of benefits is misleading. Insured health plans, such as the one at issue in this case, must comply with certain state insurance laws under the "insurance savings clause" set forth in 29 U.S.C. § 1144(b)(2)(A). See, e.g., Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003).

Tenet disclosed all required materials under 29 U.S.C. § 1024(b)(4) and 29 C.F.R. § 2560.503-1. It is not clear what additional documents the Plaintiff claims should be disclosed as relevant to a determination that the appeal was not filed in a timely manner. [3]

Since the Plaintiff has slept on its rights, and can no longer make a claim for benefits, the Plaintiff appears to be attempting to recover lost potential benefits by filing an inappropriate claim for statutory penalties. As explained in Section B.3, above, a suit for statutory penalties is not permitted where there is no concurrent claim for benefits.

Moreover, Plaintiff once again suggests that Tenet denied the claim in an effort to confuse the issues and impose penalties upon Tenet. Plaintiff claims Tenet issued an adverse benefit determination and formal denial. Plaintiff's Brief, p. 21, lines 21-23. However, PacifiCare issued this. Plaintiff further claims Plaintiff had no information to know where it stood with respect to the adverse benefit determinations. However, Plaintiff had PacifiCare's response indicating that CPT codes were needed and received its denial of the claim due to untimeliness.

In summary, Tenet has furnished to the Plaintiff all documents that must be furnished under ERISA, and no statutory penalty should be awarded.

D. Penalties Are Not Warranted Here.

No penalty for disclosure violations should be assessed in this case because the Plaintiff lacks standing, as explained in Section B, above. Even if the Plaintiff had standing, the Plaintiff has been furnished all documents requested by Plaintiff which are required to be furnished under ERISA, as described in Section C, above.

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[3] The Plaintiff claimed that Tenet failed to provide adequate notice of this adverse benefit determination, as required by 29 C.F.R. § 2560.503-1 paragraph (h). As indicated above, the notice was adequate. In any event, the Plaintiff's assertion is irrelevant to this case for document disclosure violations because the notice is not among the documents for which the Plaintiff made a written request.

Even if documents required under regulations could be the basis of statutory penalties, which we dispute, the documents requested by the Plaintiff are not described in the regulations. The Plaintiff's claim for benefits due under the plan was denied because it was not filed in a timely manner. To the extent that documents requested by the Plaintiff have not been furnished to the Plaintiff, they have nothing to do with the time at which the benefit claim was filed, and are not relevant to the denied claim. Therefore, the requested documents need not be furnished under the regulations.

As explained in Section C, above, Tenet has provided to the Plaintiff all documents required to be furnished under the statute. While documents required under regulations are not subject to the statutory penalties, as explained in Section C, above, Tenet has furnished the Plaintiff with all documents required by the regulations. In the event the Court determines that there are additional documents that should be furnished to the Plaintiff, no penalties should be awarded with respect to those documents which are beyond Tenet's control, as set forth in 29 U.S.C. § 1132(c)(1).

Furthermore, the Court has authority to decline to impose penalties. Graeber v. Hewlett Packard Income Protection Plan, 281 Fed. Appx. 679, 681 (9th Cir. 2008); 29 U.S.C. § 1132(c).

Dated: May 12, 2010

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